outlook

the official journal of the National Emergency Nurses' Affiliation Inc.

Volume 32, Number 2, Fall 2009

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NENA

outlook
Guidelines for submission

Editorial Policy

1. **Outlook** welcomes the submission of clinical and research articles, case studies, and book reviews relating to the field of emergency nursing.

2. Statements or opinions expressed in the articles and communications are those of the authors and not necessarily those of the editor, publisher or NENA. The foregoing disclaim any responsibility or liability for such material and do not guarantee, warrant or endorse a product or service advertised in this publication, neither do they guarantee any claim made by the manufacturer of such product or service.

3. Authors are encouraged to have their articles read by others for style and content before submission.

Preparation of Manuscripts

1. The original copy of manuscripts and supporting material should be submitted to the **NENA Outlook** editor. The author should retain one complete copy.

2. Manuscripts must be typed, double-spaced (including references), on 8 ½" × 11" paper with adequate margins. Manuscripts longer than one page must be submitted in a disk format in Word Perfect or Word. Submissions are accepted via e-mail to the communication officer.

3. Author's name(s) and province of origin must be included.

4. Clinical articles should be limited to six pages.

5. Direct quotations, tables and illustrations that have appeared in copyrighted material must be accompanied by written permission for their use from the copyright owner, and original author and complete source information cited.

6. Photographs of identifiable persons, whether patients or staff, must be accompanied by signed releases, such as the following: "I hereby give (author's name) authorization to use the photograph of (subject's name) in the **NENA Outlook**."

Please submit articles to:
Stephanie Carlson, Outlook Editor,
Box 31E, R.R. 1, Station Main,
Regina, SK S4P 2Z1
e-mail: communicationofficer@nena.ca

Deadline dates:
March 1 and September 8

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Cover image of the H1N1 virus courtesy of the Public Health Image Library, http://phil.cdc.gov

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President's message

It's late fall already!

It's hard to believe that my last message was on Canada Day, and now we are well past Labour Day! I just want to keep everyone informed on what we have been doing nationally to represent the emergency nurses of Canada.

Website

The new website launched on July 1 with only a few technical glitches. Everything was resolved within a few days and we are continuing to track issues and resolve them as they arise. I encourage you all to check out the new site and get involved in the discussion forums. If you are having trouble finding things, please leave a message in the discussion forum so that we can address it.

Membership

Thanks to those of you who have renewed your membership. I am sending this message to last year's members as well in case you've "forgotten" over the summer (because I am sure it's a priority when competing with the beach to renew your membership).

Please renew your membership. Your membership in NENA gives us a national voice as emergency nurses across the country. You will see below some of the things we have been able to do (and even some that we've not spent money on that are having an impact).

Emergency Nurses Day

The first week of October was Emergency Nurses Week/Day. If you would like to order some posters and things for your department, please do so from the U.S. Emergency Nurses Association at www.ena.org. Once again this year, they have graciously included our logo on their poster, as a partner of theirs.

Working together

As I stated earlier in my term, one of my goals is to bring the WHOLE country together under NENA. To that end, I have been busy starting to do some behind-the-scenes work. I have done nothing formal at this point, but just to let you know that I have been having conversations with the areas of the country that aren't currently in NENA and hope that we can all at least develop a relationship of some kind.

As well, I have had contact with ENA in the United States to discuss how our organizations can work more closely together and will be attending their board meeting in October in Baltimore and having further discussions there.

Being active

Through a gracious sponsorship opportunity from Roche Pharmaceuticals, six members of our board of directors attended a session in Ottawa in July to learn about how to take our message to government and become more politically active.

The two-day session was done at no cost to NENA and was a valuable experience that included spending the day with the Hon. Don Boudria learning the ins and outs of Parliament Hill (and actually visiting the ins and outs!).

Stay tuned as we become more active around the current pandemic and other issues of interest nationally over the next few months. If you have ideas and want to help out, please get in touch at **president@nena.ca** and we'll get you involved!

Other activities

Since my last contact, I have been to the Emergency Nurses Association of Ontario Board of Directors' meeting and met the board there and shared our national vision. They are also looking for people to get involved, so if you're interested in helping out, give them a call (if you're a member of NENA, you are also a member of ENAO). I was able to group this visit together with another trip to Ontario, so this was done with no travel costs to NENA!

I spoke to the CNA board and audience in Ottawa in mid-September about the state of overcapacity protocols and overcapacity emergency departments, as they look to review their position statement. It is a great honour for NENA to be invited to present in this area. The cost of this is being covered by the CNA.

We have also put together our pandemic messaging and action plan and are hoping to speak to the House of Commons Health Committee in the future about the issues that emergency nurses are facing in dealing with the pandemic. We have been lucky to make contacts that can help this happen once we develop our plan.

I attended the Alberta provincial conference and AGM in early October, and met many of you there.

I attended the United States Emergency Nurses Association board meeting and annual conference in the first week of October and discussed further strategic partnerships, which may provide an opportunity for our two organizations to work together.

I also attended the Emergency Nurses Association of British Columbia's (formerly ENGBC) annual conference and meeting at the end of October.

Our national board met in the first week of November…

Wow, so much going on!

Policy and position statements revision

At the fall board meeting in November, your NENA board of directors reviewed and revised the policies and position statements of the organization. I encourage you all to get involved in the process.

If you have any comments on our position statements or policies that you want to change, please e-mail your suggestions to Cate McCormick at **secretary@nena.ca** and she will forward your suggestion to the person responsible for reviewing that position statement.

This is your chance to get involved. All of the position statements and documents can be located on the NENA website at **www.nena.ca**.

Being nationally active

At the spring meeting, the NENA board of directors determined it a priority that the national president or executive attend provincial meetings and conferences to increase the visibility of NENA and the interaction with members. I am pleased to report that, to date, I have attended the following provinces and met with members either at a conference or board meeting: Saskatchewan, Ontario, Manitoba, Nova Scotia, British Columbit and Alberta.

So that leaves the rest of you still on my list… but good progress for only a few months, and we're continuing to plan when and where would be the best time to meet with members.

Carry on…

I want to thank each and every one of you who continues to show up every day in the face of a pandemic, increased patient volume, overcrowding and whatever else is going on.

I encourage you to get active nationally and provincially. If you aren't sure what you can do, contact your provincial organization or contact me directly at **president@nena.ca**. You can also stay in touch on the website!

Landon James, RN, BSN, MA, CEN

From the editor

With the spectre of the impending second wave of the H1N1 virus, the media would lead us to believe that nurses have nothing to do but stockpile N95 masks and look forward to whatever may come. Of course, the media often fails to get things right. Our emergency departments continue to struggle with the ongoing difficulties of admitted patients, staff shortages, and a parade of critical and not-so-critical patients passing through our departments. A tsunami of flu-infected patients will only exacerbate resources that are already stretched to the limit, especially as some, or many, frontline workers will undoubtedly be downed by the virus.

This is a good time for us to pay extra attention to the friendship needs of our coworkers, to go the extra mile to be thoughtful, to try to smile when you are frustrated and to pat a back instead of pointing a finger in the face of shortcomings. It's also a good time for making time for personal needs outside of work. When stressors at work are overwhelming, going home to people you love, spending time with friends, and engaging in activities you enjoy are like a balm for the soul.

So, I invite you to sit back with a cup of tea or coffee and read through this edition of the **Outlook,** as you rejuvenate between shifts. There's a little for everyone and all of it came from people like you and me who have emergency nursing in our hearts. May this **Outlook** give you some encouragement, as you respond to the crises that walk through your emergency department door. As Bette Davis's character in *All About Eve* said, "Fasten your seatbelts. It's going to be a bumpy night."

Stephanie Carlson, RN
Communications Officer

Treasurer's welcome

Thank you for allowing me to introduce myself to you as your new treasurer. I'm excited about this opportunity to be more involved with an association that I have been proud to be a member of for the past several years.

I am an emergency nurse who has worked in emergency for the entirety of my career. I graduated from the University of Manitoba with a Bachelor of Nursing and began my emergency career at Health Sciences Centre in Winnipeg. I managed to make my way out to Vancouver and have called Vancouver General Hospital my home base for the past four years. As you get to know me you will realize that I like to stay busy and experience as many things as I possibly can. As such I have enjoyed working in various hospitals within Vancouver Coastal and have found a passion in teaching courses such as TNCC and ACLS. While dabbling at various hospitals and in various projects, I developed a love of teaching and now spend most of my time working as an Emergency Educator at Vancouver General Hospital.

Emergency Nursing is my passion and I'm very excited to give my time to such a great organization. What a great way to bring emergency nurses and all our quirkiness together in a positive and energizing way.

Thank you for this opportunity and I look forward to sharing your voice in emergency nursing across the country.

Sincerely,

Lori Quinn, RN, BSN, CEN
Treasurer, NENA
treasurer@nena.ca

Awards of Excellence

Do you have an idol? Someone who helped you through that long day, evening, or night shift in ER? Well, NENA wants to hear about them! NENA is looking for nominations for Awards of Excellence in emergency nursing. There is no limit to the number of awards that are awarded in four categories: Emergency Nursing Practice, Emergency Nursing Research, Emergency Nursing Administration, and Emergency Nursing Education. The nomination form is on page 34.

Pandemic H1N1 2009 advocacy plan

Purpose

- To represent the emergency nurses of Canada to National partners in government and industry to ensure the protection of the emergency nurses of Canada.
- To establish NENA as the organization requiring consultation at the federal level for large scale events impacting emergency nurses and emergency departments.

Actions

- Provide letter to all NENA 2008 and 2009 members to sign and send to the federal and provincial governments requesting that NENA be consulted on all policy changes and decisions that will impact nurses.
- These may include infection control procedures, patient screening procedures, isolation issues, antiviral use and access, vaccine use and access.

Timeline

- Initial letter to be sent to federal health minister by president immediately (shown on page 7).

If no reply:

- Sample letters to federal health minister to be provided to NENA members by third week of September for campaign (page 8).

Evaluation

- Evaluation of plan to be discussed at the fall board meeting.

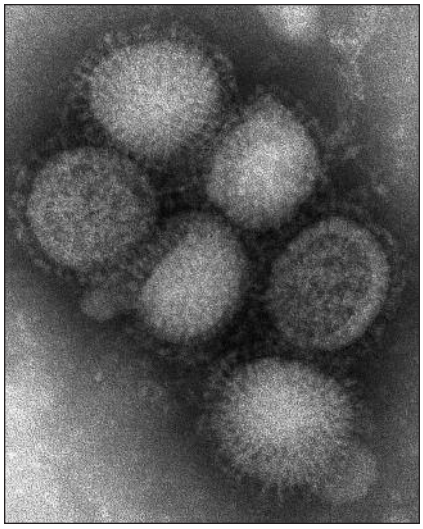
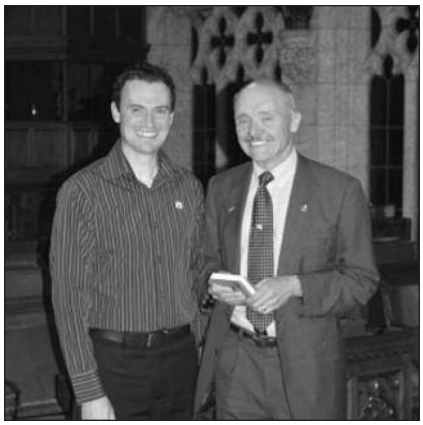


Image of the H1N1 virus courtesy of the Public Health Image Library, http://phil.cdc.gov

outlook
NENA at work

Advocacy workshop

On July 17–18, six members of the NENA BOD, Landon James, Stephanie Carlson, Cate McCormick, Leslie Olson, Irene Osinchuk, and Jan Spivey, went to an advocacy workshop in Ottawa, which was funded by Roche. This was a fantastic workshop and much was learned. We had the privilege of getting a tour of Parliament Hill by the Hon. Don Boudria, and he also gave us a brief overview of the Canadian Parliamentary system.



Landon James, NENA president, tours Parliament Hill with the Honourable Don Boudria.

During these two days, we learned about grassroots lobbying and advocacy in Canada—the facilitator, Michelle McLean, was great and had our undivided attention throughout the whole workshop. She provided a case study on how to effectively organize a national campaign based on her experience in the past.

On day two, we designed an advocacy campaign for NENA that was to address the pandemic and the use of antiviral medications, which Michelle helped us to develop. The framework that we used could be applied to any scenario. By the end of the day, we had gained the basic knowledge and tools to do an advocacy campaign.

The six of us came away from this workshop enlightened and motivated to jump in and advocate! Since the workshop there have been many behind-the-scenes draft letters and questions to the NENA BOD asking how best to advocate for emergency nurses across Canada. At present, all provincial directors are sending a letter to their MPs regarding the pandemic and requesting information about plans to deal with the potential crisis.

Continue to check the NENA website as updates will be posted regularly regarding the progress of our advocacy campaign.

Cate McCormick, RN, BSN, ENC(c)
NENA Secretary

National Emergency Nurses Affiliation
Landon James, President
203, 55 East Cordova Street
Vancouver, BC V6A 0A5

September 6, 2009

Honourable Leona Aglukkaq
Minister of Health
70 Columbine Driveway, Tunney's Pasture
Ottawa, ON K1A 0K9

RE: PROTECTING CANADA'S EMERGENCY NURSES DURING A PANDEMIC

The National Emergency Nurses' Affiliation (NENA) is Canada's nationally recognized organization that represents emergency nurses. NENA, which is an affiliate of the Canadian Nurses Association, is the source of best practices and standards for the emergency nursing profession.

I am writing today as the President of NENA and a front-line emergency nurse to express my concern about the government's plan for the protection of emergency nurses during a pandemic. While NENA appreciates your leadership during this pandemic period, we believe that more consultation with our National Affiliation is required in making decisions that will affect emergency nurses at the bedside. I urge you to establish a formal relationship with the National Emergency Nurses Affiliation with regards to issues such as isolation procedures, protection of health care workers, antiviral use and vaccine access.

A pandemic influenza outbreak has the potential to seriously compromise the health system in Canada. As nurses are the foundation of our health system, and emergency nurses will be on the front lines during a pandemic, we wish to support the government in taking appropriate measures to ensure their protection. Research supports many health and economic benefits of the early use of antivirals, access to vaccines and proper infection control procedures. Our nurses across the country are receiving various different messages about the above issues and our organization has the ability to assist with standard message delivery to the emergency nurses of Canada.

The emergence of the novel H1N1 virus this spring has challenged both health professionals and governments to be well prepared for a possible second wave of the pandemic this fall. NENA would welcome a meeting to discuss this critically important issue with you in the near future.

Sincerely,

Landon James, RN, BSN, MA, PCP
NENA President 2009–2011

Fall 2009

Honourable Leona Aglukkaq
Minister of Health
70 Columbine Driveway, Tunney's Pasture
Ottawa, ON K1A 0K9

RE: PROTECTING CANADA'S EMERGENCY NURSES DURING A PANDEMIC H1N1 2009

The National Emergency Nurses' Affiliation (NENA) is Canada's nationally recognized organization that represents emergency nurses. NENA, which is an affiliate of the Canadian Nurses Association, is the source of best practices and standards for the emergency nursing profession.

I am writing today as an emergency nurse to express my concern about the government's plan for the protection of emergency nurses during a pandemic. While NENA appreciates your leadership during this pandemic period, we believe that more consultation with our national affiliation is required in making decisions that will affect emergency nurses at the bedside. I urge you to establish a formal relationship with the National Emergency Nurses' Affiliation with regards to isolation procedures, protection of health care workers, antiviral use and vaccine access and use.

A pandemic influenza outbreak has the potential to seriously compromise the health system in Canada. As nurses are the foundation of our health system, and emergency nurses will be on the front lines during the pandemic, the government must take appropriate measures to ensure their protection.

The emergence of the novel H1N1 virus this spring has challenged both health professionals and governments to be well prepared for a possible second wave of the pandemic this fall. As part of that planning, we encourage you to involve NENA in the revisiting of Canada's policy on this issue and, specifically, the use of antivirals and vaccine access.

We would welcome a meeting to discuss this critically important issue with you in the near future and ask you to contact our national President, Mr. Landon James, to arrange this meeting. He may be reached at **president@nena.ca**.

Sincerely,

_____

Name

Call for nominations: "president-elect" and "communication officer"

Are you interested in serving on the board of directors? Then read on—this year there are two available positions. The president-elect position is a one-year term preceding the presidential role, and the communication officer position is a two-year term. Both positions would begin following the annual general meeting in Banff, AB. The board of directors meets twice yearly. Both meetings are three days in length. Typically, the spring meeting, though, is held in conjunction with a regional or national conference, so time away from home is usually longer.

As president-elect you are a vital member of the board. You would be expected to assume the role of president if the current president were to resign. Other duties include: reviewing and revising (as needed) the policy manual, position statements, bylaws and preparing achievements and actions in the strategic plan. There may be other duties that would be assigned to you by the president.

As communication officer, you are expected to ensure the production and dissemination of the **Outlook** journal every six months. You will liaise with provincial communication officers to encourage members to submit articles, pictures, tips, etc., to the journal. You will establish and maintain a credit rating with a printing firm for the production of **Outlook**. You will ensure that all invoices for the production of the journal are correct and are submitted to the NENA treasurer for payment. You will also maintain a liaison with NENA webpage designers to ensure updated information is displayed, and you will act as a contact resource for affiliation members who wish to use the website services. You will also assist with national and regional conferences by acting as a liaison between the conference committee and the board of directors.

Two NENA members must nominate candidates and the nominee must be a NENA member in good standing. A nomination form has been included for your use. Please forward a completed nomination and curriculum vitae to Sherry Uribe. Her address is listed on the nomination form. Nominations for these positions may also be made from the floor at the AGM. Announcement of successful candidates will be made following the election at the AGM in Saint John, NB.

outlook
Nomination Form

NENA executive position

Positions:

- Communication Officer
- President-elect

We, the undersigned voting members of NENA, do hereby nominate:

_____
for the position of

_____
on the NENA executive.

_____
(nominee) is in good standing with NENA.

1. Name: _____

Date: _____

Signature of nominator: _____

2. Name: _____

Date: _____

Signature of nominator: _____

I, _____,
do hereby accept this nomination for the position of

_____
on the NENA executive.

Signature: _____

Date: _____

Please return this letter of intent and CV, by April 15, 2010, to:
Sherry Uribe, RR 5, S10 C7
Oliver, BC V0H 1TO
e-mail: nominations@nena.ca

Report of the Fall NENA board of directors' meeting

Dianne Quinn and Fraser MacKinnon.

By Cate McCormick

The NENA BOD met November 6–8 in Toronto. The board members worked hard and much was accomplished. Below is a brief summary of the meeting's highlights:

- New board members were installed.
- Two new position statements were adopted and added to the website:
  - *Pandemic H1N1 2009,* and
  - *Care of the Sexual Assault Patient in the Emergency Department*.
- NENA conference 2010 will be held in Saint John, New Brunswick
- Leslie Olson of Alberta created a **NENA Board Members' Handbook** to aid new BOD members in assuming board duties.
- All professional practice documents were revised and uploaded to the website.
- We met with NCAC and welcomed the new NCAC members.

Above, Tanya Penney, second from left, and Irene Osinchuk, far right, join other emergency nurses to rewrite the emergency nursing certification exam.

Above, NCAC members met with NENA board members.

The 2009–2010 board of directors.

- We reviewed the membership application process. We will discuss having the membership year begin on the date of payment (instead of running July 1–June 30) at the AGM in St. John, NB. We believe this change would be well received by NENA members.
- ENGBD is now called ENABC.
- The board made a list of recommendations for improvements to the website so that members will be better able to find documents and postings. These will be made gradually over the next few months.

Lots of hard work was put into this meeting and, if you get a chance to look at the NENA website, you will get to see a bit of the work we did.

Cate McCormick, Secretary, and Landon James, President, at work.

Lori Quinn, Sherry Uribe and Cathy Fewer.

Outgoing NCAC members Pat Walsh and Kathy Woloshyn with NENA President Landon James.

National Emergency Nurses' Affiliation Inc. profit and loss, accrual basis—all transactions

Ordinary Income/Expense

INCOME	
Membership Fees	
Independent	205.00
International	60.00
Total Membership Fees	265.00
1100—Indirect Fees	
1101—TNCC	15,690.00
1102—ENPC	6,270.00
1103—CATN	1,320.00
Total 1100—Indirect Fees	23,280.00
1500—Affiliate Revenue	
1502—Affiliate Membership Fees	12,725.00
Total 1500—Affiliate Revenue	12,725.00
1600—Marketing	
1601—Print Advertising	53.98
1602—Website Advertising	325.03
Total 1600—Marketing	379.01
1700—Special Events Income	
1750—Conference Revenue	2,125.00
Total 1700—Special Events Income	2,125.00
1900—Other Types of Income	
1901—Miscellaneous Revenue	50,375.00
Total 1900—Other Types of Income	50,375.00
TOTAL INCOME	**89,149.01**
EXPENSES	
8300—Travel	
8301—Air Travel	7,588.05
8302—Ground Travel	981.50
8303—Lodging	1,928.37
8305—Per Diem	2,050.00
8300—Travel—Other	150.00
Total 8300—Travel	12,697.92
8600—Membership Services	
8620—Website Services	5,181.00
Total 8600—Membership Services	5,181.00
8700—Executive Services	
8710—Laptop Computers (Capital)	399.25
Total 8700—Executive Services	399.25
8900—Administration Expenses	
8910—Postage and Delivery	240.26
8940—Printing	261.00
Total 8900—Administration Expenses	501.26
TOTAL EXPENSES	**18,779.43**
NET ORDINARY INCOME	**70,369.58**
NET INCOME	**70,369.58**

National Emergency Nurses Affiliation (NENA) Conference

By Major Rhonda Lee Crew, RN, BScN, CD, CHE

It was a windy and unusually warm April day in Winnipeg, MB. My colleague Capt. Bannerman and I were attending the NENA conference. Other than the organizers, we were the first to arrive (not unusual for military personnel). We took our seats and waited for the day to begin. Upon the beginning of the opening ceremonies, we noted that we were still sitting alone, despite the room being full and joked that maybe it was because everyone knew we must be proficient in weaponry, as we are in the military.

The morning went well and we enjoyed the discussions very much. After lunch, it was my time to present. I provided a presentation on life in Kandahar, Afghanistan, and working at a Role 3 medical facility there. I also discussed how the aeromedical evacuation role is currently to pick up our injured soldiers from Landstuhl, Germany, for strategic aeromedical evacuation to Canada. I laughed and said how nurses around the world are all alike, and that the American nurses we ran into were always looking for Canadian pins and paraphernalia. Following my presentation there were numerous questions—I was surprised to see how interested my civilian colleagues were in what is happening around the world, what the military is doing, and what can be done to support our soldiers. When my discussion ended, everyone in the room gave both Capt. Bannerman and me a standing ovation—specifically thanking us for the sacrifices that we make in support of our nation.

The applause and appreciation did not end there. From that point on, Capt. Bannerman and I did not sit alone, and we were constantly engaged in conversations about the military and the sacrifices that our soldiers make. In addition to the popularity we had attained, we also received a large bag full of Canadian maple leaf pins, which were generously donated to every attendee by the Pin Man Company, and which were then generously donated to Capt. Bannerman and me by most attendees to provide to our American colleagues.

I was, and continue to be, overwhelmed by the response that we received at the conference. The presenters, sessions, displays, company representatives and various vendors were pleasant, giving and very knowledgeable.

By the end of the conference, yet another warm and windy day in Winnipeg, MB, I knew that the NENA conference had been a great success. Not only am I now a member of NENA, I am eagerly waiting to attend next year's NENA conference. I encourage anyone with an interest in emergency nursing to join me.

Board meeting observer policy

NENA Policies & Procedures 5 . 6 . 0

NENA board of directors' meetings are open to NENA members on a pre-arranged basis.

The objectives of open board of directors' meetings are to enhance the board's accountability to those who have an interest in the affiliation's affairs and to facilitate member understanding of the board's governance of the emergency nursing specialty.

Observer policy

- Those wishing to observe a NENA board of directors' meeting will contact the NENA president with their wish to do so at least 30 days prior to the board meeting, when possible.
- Number of observers allowed will be at the discretion of the board.
- If the request is less than 30 days in advance of a NENA board of directors' meeting, it will be at the discretion of the NENA executive whether permission will be granted.
- All observers shall be identified at the beginning of the meeting.
- A review of observer expectations will be outlined at the start of the meeting and is as follows:
  - i. Observers, prior to the start of the meeting, must agree to confidentiality of matters discussed.
  - ii. Observers will not be allowed to attend in-camera sessions.
  - iii. All observers will have non-voting status.
  - iv. Observers may not enter into the discussion of the business of the board.
  - v. The observer may comment in writing to their official representative while the meeting is in progress.
  - vi. Observers cannot be elected to chair a standing committee.
  - vii. Observers will be placed in a row behind the table where the meeting is held, depending on the number of observers present.
  - viii. NENA, Inc. will not be responsible for any expenses incurred by the observer attending a NENA board of directors' meeting (i.e., meals, accommodation, travel, etc.).
  - ix. If any observer becomes disruptive, they will leave the BOD meeting immediately on the request of the president.

Riding the Wave of Change

NENA National Emergency Nursing Conference
Hilton Hotel & Conference Centre,
Saint John, New Brunswick
May 6–8, 2010

Call for abstracts

"The times, they are a-changing, and ED nurses must be prepared to Ride the Wave."

The New Brunswick Emergency Nurses' Association (NBENA), along with The National Emergency Nurses Affiliation (NENA), invites all interested to submit abstracts for oral and poster presentations at the upcoming NENA conference in Saint John, NB, May 6–8, 2010.

Conference presentations will be organized into four tracks: clinical practice, leadership, education and emerging issues.

All abstracts will be peer reviewed. The primary presenter for each accepted oral presentation will be awarded free registration for the conference day on which they present.

Abstracts must be received by December 15, 2009. Those individuals whose abstracts are selected for presentation will be notified by December 30, 2009.

Abstracts will only be accepted electronically in Microsoft Word.

Please ensure that your submission includes:

- A cover page identifying the name(s) of the presenter(s), professional credentials, current position, e-mail address for correspondence and contact phone number
- A maximum 500-word summary of the presentation, which includes title, learning objectives and implications for emergency nursing practice

Please direct abstracts and/or questions to ***golhi@reg2.health.nb.ca***

outlook
NENA at work

Canadian Triage and Acuity Score (CTAS)

The roll-out of the latest edition of the Canadian Triage and Acuity Score (CTAS) course has been going very well across Canada. CTAS has also caught the attention of countries around the world including the U.S. Taiwan, Trinidad and Tobago, and Japan are using or are in the process of switching to CTAS as their national triage standards. We are also receiving regular site-based requests from various other countries requesting access to our teaching material—all extremely exciting for Canada. We are seen as the global leader in emergency department triage.

Nationally, in July 2009, there was a call out to all instructors to renew their status with the CTAS National Working Group and, to date, approximately 70 instructors have renewed.

We have also partnered with the Emergency Medical Services (EMS) committee of the Canadian Association of Emergency Physicians to create a Canadian Prehospital Acuity Score for our EMS providers across the country. This will allow us to all "speak the same language". This is currently under development, so stay tuned.

If you have any questions, please do not hesitate to contact us at **ctas@nena.ca**

outlook Bouquets

Thank you to **Jan Calnan,** of Victoria, BC, and to **Jerry Bell,** of Regina, SK, for many years of faithful and creative service to NENA as secretary and treasurer. Their total man-years of service to NENA exceeds the ages of many NENA members. Each of them has given tireless service on the NENA board of directors beyond the expectations of their roles. NENA owes a great debt of gratitude to both of them for the consistent excellence that they brought to their positions. You will be missed

Above, Jerry Bell and Jan Calnan

Congratulations to **Cate McCormick** of Kentville, NS, who was elected to the position of NENA secretary. She leaves the duties of provincial director for Nova Scotia and PEI

Congratulations to newcomer-to-the-NENA-board, **Lori Quinn**, who was elected to serve as NENA treasurer. Lori is a NENA member from Vancouver, BC

Welcome to **Fraser MacKinnon,** who has joined the NENA board as Nova Scotia/PEI Provincial Director

Welcome to **Sharron Lyons,** new section editor of the Kids' Corner in the **Outlook**

Congratulations to **Michelle Taggart,** NENA member from Calgary, on receiving the *Editor's Award* to further her research on nursing attitudes toward health promotion and patient education. Congratulations to **Sharron Lyons** of Vancouver, BC, on receiving the *Margaret Smith Pediatric Bursary,* and to **Lisa Powell** of Winnipeg, MB, and **Patricia Krukowski** of Calgary, AB, on being awarded *NENA Bursaries*

Many thanks to **Gary Pronych,** who designed the new NENA website, and who, with **Landon James** and **Lori Quinn,** has worked diligently to learn its intricacies and fine-tune it

Thanks to each NENA member for your patience as we launched the new website and worked out the bugs

Congratulations to **Sharron Lyons** on receiving the *NENA Award of Excellence in Nursing Practice* and to **Lori Ulrich** of Winnipeg, MB, the recipient of the *NENA Award of Excellence in Nursing Education*. The nomination and recognition by their peers is a tribute to the skill that each of these nurses brings to our profession

We wish to thank **Valerie Eden** from Nova Scotia (past member of the National and Provincial Board and longtime member of NENA) for her contribution in developing the position statement related to Internationally Educated Nurses. As always, your contributions and assistance are invaluable

By Carole Rush

Background info on NENA's Course Administration Committee (NCAC)

Purpose

To administer, deliver and evaluate aspects of the TNCC, ENPC and CATN-II courses, and to administer all other NENA-sponsored courses as requested by the NENA Board of Directors.

At this point in time, NCAC is not directly involved in the administration of the CTAS Triage Course; administration is through the CTAS National Working Group, of which NENA has representation. CTAS course database and information is maintained by the Canadian Association of Emergency Physicians (CAEP). If you have an inquiry about the CTAS course, please e-mail **ctas@nena.ca**

Responsibilities

- To follow course contractual agreements between NENA and the Emergency Nurses Association (ENA) in the United States.
- To maintain administrative procedures as established by governing bodies of said courses.
- To make and administer policies to facilitate the management and evaluation of courses.
- To manage the associated Quality Assurance process of instructors and courses.

Specific ways NCAC can help you

- Put you in touch with local TNCC, ENPC and CATN-II instructors/course directors in your area.
- Identify areas in need of more instructors and help facilitate instructor courses.
- Assist with resolution of difficult course issues you may have.
- Facilitating instructor updates when courses are revised.
- Providing you with a current Canadian Course Administration manual, which should answer your questions about running courses in Canada.

Qualifications of members

- Must maintain current NENA membership.
- All NCAC members will be an instructor trainer (IT) in either ENPC/TNCC or a course director of CATN II.
- Will have current emergency experience in any one of the following areas of practice: clinical, education, administration, or research.

All members of NCAC are volunteers and undertake their responsibilities in addition to their work duties. We hold two face-to-face meetings per year. The remainder of our communication is through e-mail.

Thank you to outgoing NCAC Members

NCAC appreciates the time and efforts of **Pat Walsh**, outgoing Eastern Canada Rep, and **Kathy Woloshyn**, outgoing Central Canada Rep. Both Pat and Kathy have served on NCAC for many years and have made significant contributions to the dissemination of courses and to the overall goals of NCAC. Pat served as NCAC Chair for several years and has contributed her knowledge and skill to the development of the new NENA website. Kathy was a contributing member of ENA's ENPC Revision Workgroup that produced the current 3rd edition ENPC Course.

Welcome to new NCAC Members

NCAC welcomes incoming Eastern Canada Rep, **Traci Foss-Jeans**, TNCC Instructor Trainer (resides in Grand Falls-Windsor, Newfoundland) and **Brenda Lambert,** TNCC/ENPC Instructor Trainer, incoming Central Canada Rep (resides in St. Thomas, Ontario). Both Traci and Brenda will attend the fall NCAC meeting November 6–8 and assume their committee duties after this meeting.

Course Administration Updates

Attention Course Directors!
Send NENA Indirect Fees to new NENA Treasurer

Lori Quinn, NENA Treasurer
101, 1001 West Broadway—Unit 167
Vancouver, BC V6H 4E4
E-mail inquiries: **treasurer@nena.ca**

Please include the appropriate paperwork when sending your Indirect Fees to the NENA Treasurer. There is an ongoing problem with cheques being sent to the NENA Treasurer without the appropriate information (course number, number of participants, course director, province where course was held).

NCAC wishes to recognize and thank Jerry Bell for his dedication to the role of NENA Treasurer, processing of all those course fees, and liaison with the NCAC Committee.

Revised Canadian Course Administration and Resource Manual

As per the contract between NENA and ENA, Canada does follow the ENA Administrative Guidelines for TNCC, ENPC and CATN-II courses. We are permitted to customize some administrative procedures; NCAC has developed a Canadian Course Administration Manual, which was last revised in 2006.

We have just finished revising this manual again, entitled, **"Interim Canadian Course Administration and Resource Manual"**, which will be in effect until the online course application process is available through **www.nena.ca**. You can download this interim manual from the NENA website.

NENA recruitment/ retention Powerpoint presentation

Course directors are asked to include the new NENA recruitment/retention slide presentation during their TNCC, ENPC and CATN-II courses. This presentation

can also be shown during conferences and other educational events. You can download the PDF version of "NENA Recruitment PowerPoint" from the NENA website at **www.nena.ca**.

Current NENA membership required of all instructors

A reminder that all instructors/course directors teaching in Canada must have a current NENA membership. It is the individual instructor's responsibility to renew, but NCAC is asking that course directors also ensure their instructors are current.

Course applications to ENA/ENA Course Operations Canadian Liaisons

Course directors are still asked to submit their course applications to **courseops@ena.org** when submitting them via e-mail, as someone is always monitoring this e-mail address regardless of who is out of the office.

ENA has designated two staff members, Mary Caplis and Amanda Holubar, to serve as liaisons for our Canadian courses. Both Mary and Amanda have other duties at ENA, but will be most familiar with Canadian issues.

Course directors can contact Mary directly at **mcaplis@ena.org** and Amanda at **aholubar@ena.org** for specific questions about their course applications or course materials.

We will let course directors know when the process will be changing over to submitting course applications directly to NCAC via the NENA website.

All course manuals and materials will continue to be shipped from the ENA Office.

Update on French Translation of ENPC and TNCC course materials

NCAC appreciates the efforts of Claire Thibault, Senior Advisor, MUHC Pediatric Network in Montreal, and the McGill University School of Translation, for the translation of our course materials. NENA has financially contributed to this project, which has been subsidized by McGill.

TNCC 6th Edition

- Both Exam A and Exam B have been translated.
- McGill is currently translating the slides (anticipate completion late Fall 2009) and will then start translation of the Provider manual.
- Course directors who have French-speaking TNCC course participants can request available French course materials from the NCAC Chairperson at **chairncac@nena.ca**

ENPC 3rd Edition

- Exams, slides and Provider manual have been translated.
- An ENPC course in October 2009 at Montreal Children's Hospital (affiliated with McGill) will trial the French course materials.
- NCAC will be discussing reproduction/distribution/purchase price of this French ENPC package with both ENA and NENA Board of Directors.
- ENPC course directors with French-speaking participants can contact NCAC Chair for more details on the availability of these materials.

Instructor courses in Canada

NCAC endorses the dissemination of courses throughout the country and encourages the development of new instructors. If you require an instructor course in your area, please send a letter of intent, outlining the rationale for more instructors, to NCAC members at **ncac@nena.ca** prior to requesting your course.

Requesting course directors/instructors from the U.S. to teach in Canada

There have been a few situations in the past six months where U.S. instructors were asked to teach courses in Canada. As per our course contract with ENA, NENA has agreed to handle course requests and needs in Canada. If Canadian instructors are not able to meet the course needs, then instructors from other countries will certainly be considered/invited to teach. The positive side of these situations is the identified need for more instructors in certain areas of Canada. As per our Canadian Course Administrative Manual, all instructors and course directors who teach in Canada must be current members of NENA, even if they are teaching just one course. U.S. instructors would have to become familiar with specific Canadian course administrative procedures. U.S. course directors would still have to pay NENA Indirect Fees.

TNCC Update

TNCC reverification course

ENA is pleased to announce that a new TNCC reverification course, based on the 6th edition TNCC provider course, has been developed. Course directors were mailed the new CD and course information in August 2009.

Participants must have a **current TNCC provider card**, and submit a copy with their course application. The reverification course will be offered over one day. Participants do need to prepare by reading the TNCC provider manual, 6th edition, and completing a Pre-Test before the course. Key points from each lecture will be reviewed, as well as the skill stations. As with the provider course, participants must complete the written exam and the Trauma Nursing Process evaluation station.

As with the ENPC reverification course, NCAC will pilot this TNCC reverification course across Canada in the next six months. Pilot sites identified so far include Ottawa, Calgary, Red Deer, Edmonton, and Kenora. There will be other pilot courses scheduled. Course directors of these pilot courses will be asked to provide feedback on this new course. NCAC will then make recommendations as to the offering of this course in Canada.

TNCC mechanism of injury lecture

Though mechanism of injury is discussed in each chapter of TNCC, NCAC suggests that the information in the previous lecture is so valuable that you may still wish to incorporate it into your course as a lecture.

Some instructors are currently doing this and already have prepared material. Should you wish to receive the "Mechanism of Injury" PowerPoint for your 6th edition TNCC courses, simply e-mail **ncac@nena.ca** with your request. Please provide both your e-mail and mailing address; if the file is too large to be e-mailed, you will be sent a CD.

ENPC Update

ENPC revision workgroup

ENA is getting underway with the 4th edition of the ENPC course. They have formed an ENPC revision workshop and sent a survey to current ENPC instructors and course directors (deadline for responses was August 31). NCAC has asked to be involved with the revision process by reviewing written chapters, skill stations, exams during the designated content review periods. Depending on the new course design, there may be an opportunity to submit Canadian epidemiology content on pediatric illness and injury.

The 4th edition of the ENPC course is not expected to be ready until 2011.

CATN-II Update

There are currently CATN-II course directors and instructors in B.C., Alberta, and Ontario. Manitoba has started the process for two course directors. NCAC would like to see the CATN-II course offered across the country. Many course directors and instructors are willing to travel.

If you would like to host a CATN-II course in your area, please contact **ncac@nena.ca**. Maximum number of participants is 24.

Contact us: NCAC committee members

General e-mail to reach all NCAC members: **ncac@nena.ca**

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carole.rush@albertahealthservices.ca

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Traci Foss-Jeans, Grand Falls, NL
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outlook
Profile

Profile: Major Rhonda Lee Crew, RN, BScN, CD, CHE

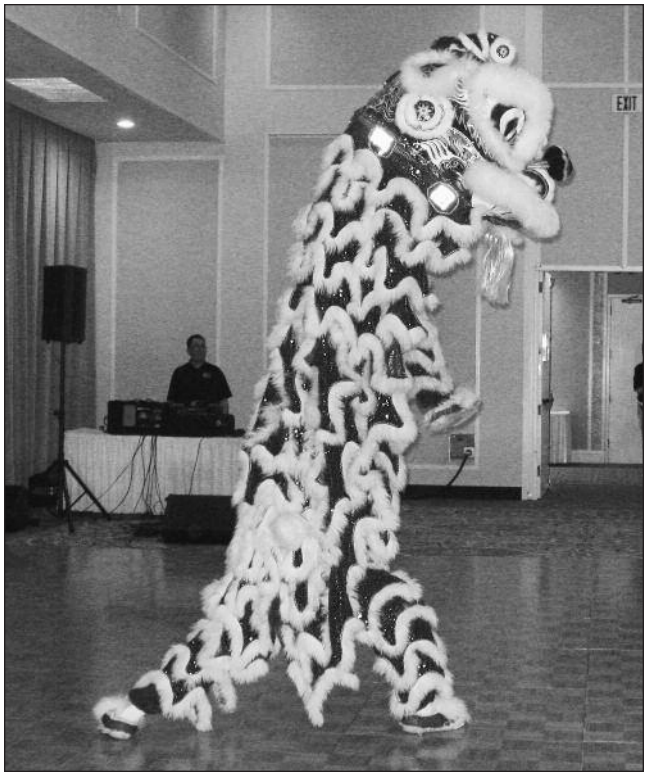
I am Major Rhonda Lee Crew. Whilst there are many labels that define me, there are three that I value most: woman, soldier and health professional. These three feel like the ones that most accurately reflect who I am and who I want to be in the world.

I am a woman. As a woman, I am the spouse of a Canadian Forces Search and Rescue Technician, Duane Bryson; I am stepmother to Alex, 10, and Jeff, 12. I am also a daughter, a stepdaughter, a sister to three sisters, an aunt to three nieces and three nephews, and a cousin and friend to many.

I am a soldier. As a soldier, I am one of the most blessed persons in Canadian society. I have been given the opportunity to serve my country and its citizens in times of peace and conflict. I have served at six different wings/bases. I have completed three tours (two to Bosnia and one to Afghanistan), and I have taken innumerable courses all while achieving the rank of Major. I am now the Flight Commander of Canada's Canadian Forces Aeromedical Evacuation Flight, and I am the Aeromedical Evacuation Senior Practice Leader for the Canadian Forces.

I am a health professional. As a health professional, I graduated as a registered nurse from the Victoria General School of Nursing, Halifax, NS, in 1992, then with a Bachelor of Science in Nursing from Dalhousie University, Halifax, NS, in 2004 and, finally, as a Certified Health Executive from the Canadian College of Health Service Executives in 2009.

Photos from the National Emergency Nurses Affiliation (NENA) Conference

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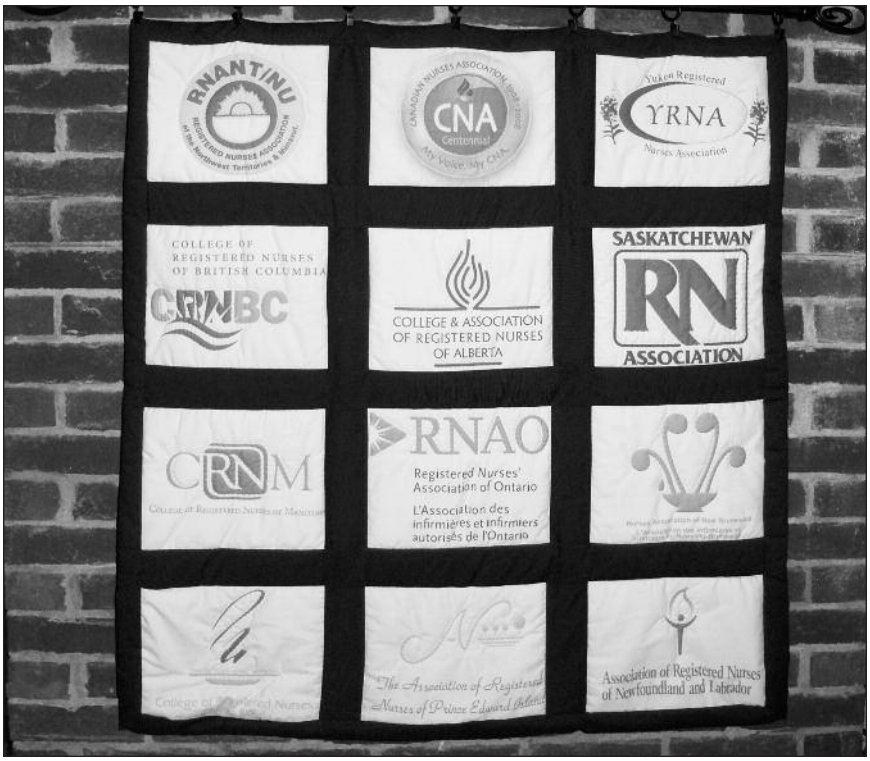
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of Newfoundland and Labrador

British Columbia

ENGBC Update

- ENGBC is now ENABC—Emergency Nurses Association of British Columbia. In late 2007 and early 2008, Professional Practice Groups were advised that under the interpreted mandate of CRNBC, it seemed unlikely that the PPGs would continue and the PPGs should look to other types of organizational structures to continue.
- ENGBC members voted to disaffiliate from CRNBC and form a non-profit association.
- September 4, 2009, ENGBC became Emergency Nurses Association of BC—S 55634.

ENABC has started out this membership very well, with 109 renewals to date, well ahead of where we were last year at this time.

ENABC hosted a two-day fall conference in Kamloops on October 25–26. Pre-conference sessions, including ENPC and ACLS, were offered on October 23–24. For more information, please check our website at **www.engbc.com**.

Our AGM was held during the conference, at which time we installed new officers, updated our members on plans to align with government agencies working to introduce mandatory gunshot/stab wound reporting and cell phone use/texting while driving a vehicle. We also asked members if we should change our logo to reflect our name change.

In September, ENABC was invited to give a presentation to BC emergency service leaders. Sharron Lyons, immediate past-president and current treasurer, gave the presentation, speaking about our goals to increase our visibility, increase our membership and what ENABC and NENA can provide to BC nurses. It was well received.

Respectfully submitted by
Sherry Uribe,
BC Director

Alberta

November 2009

ENIG currently has 140 members. Our fall conference was held in Canmore on October 2–4 with 55 attendees. Our numbers this year were down significantly, which we feel is a reflection of the economic recession combined with the uncertainty nurses are feeling with our new Alberta Health Services structure. Those attending stated that the speakers were dynamic and informative, and the evaluations provided some good feedback that we will follow in our 2010 plans.

Elections were held at the AGM, and the members of the new executive will assume their roles on July 1, 2010:

- Leslie Olson, President
- Dawn Paterson, Incoming President
- Judy Skanderup, Past-President
- Margaret Dymond, Secretary
- Julie Aceron, Treasurer
- Geri St. Jean, Communications Officer
- Karen Melon, Incoming Communications Officer

There are many challenges facing emergency nurses in Alberta. The rising influenza numbers and concern about H1N1 has seen an increase in ED volumes throughout the province of up to 45% in some areas. Nurses at triage are now wearing masks and eye shields and doing ILI screening on all patients. The public is fearful and a change in availability of immunizations brings many to the ED.

The number of admitted patients in EDs has also increased, as the need for isolation rooms on many admits makes bed placement a challenge. EDs are also holding ICU patients for a longer period, as the number of intubated rises.

Pandemic planning at site specific, regional and provincial levels has increased the workloads to all departments, and is in a "fluid" state, as information is constantly changing.

Emergency departments across the province are facing cutbacks, delays in supplies and staff mix changes, as all decisions need to be approved at a provincial board level. We understand that all departments will soon be asked to reduce costs by 3%, which will place even more stress on an already taxed health care system.

Additionally, Alberta nurses are entering into a negotiation year for their contract.

The number of staff off due to illness, specifically influenza, has led to many challenges for the EDs.

New graduates in nursing are unable to find employment in Alberta and are leaving the province.

I feel that ENIG will be challenged in the upcoming months in supporting the values we believe in while trying to work within the framework imposed on us by Alberta Health Services.

Respectfully submitted by
Leslie Olson,
President of
ENIG of Alberta

NENA Position Statement: Pandemic H1N1 2009

Approval Date: November 2009
Past Revision Dates: N/A
Next Revision Date: January 2010

Issue

H1N1 is a new influenza virus, first detected in people in the United States in April 2009, which has never circulated before. People have little or no immunity. It spreads quickly, particularly among young people (ages 10 to 45), and is spread from person to person by droplets, (cough, sneezing), as is the normal seasonal influenza. The World Health Organization announced on June 11, 2009, that a pandemic of H1N1 influenza was underway.

Signs and symptoms of infection with the H1N1 virus include fever, chills, fatigue, headache, cough, neuralgia, muscle and joint pain, sore throat, rhinitis, and sometimes vomiting and diarrhea. People may be infected with the flu, including 2009 H1N1, and have respiratory symptoms without a fever. Severe illnesses and deaths have occurred as a result of illness associated with this virus. Worldwide, 5,712 deaths have been related to H1N1 as of October 30, 2009.

Prevention methods include: covering the mouth and nose when coughing and sneezing; washing hands frequently; refraining from hand-to-mouth/-eye/-nose contact; immunization; maintaining social distance; and avoiding contact with infected individuals.

NENA Position

- Nurses have a responsibility to:
  - engage in activities to protect patients in their care; and
  - to uphold the best infection protection standards; and
  - to practise self-care to reduce personal risk of infection.
- Nurses, as part of a larger health care group, should be a priority in the Canadian vaccination program. Emergency nurses are particularly vulnerable because the emergency department is the initial point of care for most undiagnosed patients who may present with influenza-like illness. As frontline staff, nurses should be provided with the highest form of protection.
- Nurses should exert influence to promote dissemination of information related to reasonable and informed use of emergency department facilities. The CDC recommends a four-pronged approach, including:
  - eliminating the potential of exposure by encouraging people to self-isolate;
  - creating areas that will reduce the exposure to health care workers and other patients, such as barriers;
  - administrative controls, such as immunization, enforcing exclusion of ill health care personnel, creating separate triage streams for patients with influenza-like illnesses;
  - the use of personal protective equipment—in those instances where N95 is indicated (during aerosolized procedures), the use of protective eye wear and face shields should be made available as recommended by the Public Health Agency of Canada.
- An adequate quantity of antiviral medications must be available for high-risk health care workers, as defined by Public Health Agency of Canada, to decrease absenteeism in critical infrastructure areas.
- Nurses should support and promote the development of primary assessment areas other than the emergency department.
- Nurses should encourage the deployment of staff to other services in the best interest of the health care worker, such as those who fail the mask fit test and those at high risk for complications such as pregnant women or staff with chronic health conditions.
- Nurses should participate in the surveillance of patients with influenza-like illness. Nurses should be active participants in the collection, identification, and communication of data for this use. Collaboration with public health is imperative to ensure that timely and necessary information is relayed appropriately.
- Infected patients should be identified and positive swab results communicated to the health care workers who were in contact with the patient.
- We must support the development of flexible leave policies that allow the worker to stay home and care for sick family members and/or children who are released from schools or child care facilities in the event that they must close.

NENA endeavours to maintain up-to-date information, but nurses are responsible to maintain their personal education.

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NENA Position Statement: Care of the sexual assault patient in the emergency department

Approval Date: November 2009
Past Revision Dates: N/A
Next Revision Date: November 2011

Issue

- Statistics Canada estimates that one in four Canadians will be sexually assaulted in his or her lifetime.
- Expected sequelae to sexual violence may include infection and pregnancy, post-traumatic stress disorder, somatic complaints, significantly increased substance use and substance abuse, increased utilization of health care resources, impaired social interaction, and loss of productivity in the workplace, depression and suicide.
- Sensitive and timely immediate treatment and appropriate referral for follow-up physical and emotional care can improve the long-term outlook for this vulnerable patient population.
- Many emergency registered nurses have acquired specialized education as Sexual Assault Nurse Examiners (SANE). A SANE is a registered nurse with special education in the comprehensive care of sexual assault survivors, the recognition and documentation of injury, the collection of evidence, and may qualify as an expert witness in a court of law. SANE education includes crisis intervention; acute care and treatment; injury recognition and documentation; evidence detection and collection; sexually transmitted infection and pregnancy prophylaxis; appropriate referrals for subsequent care of the survivor of sexual violence.

NENA Position

- Emergency care of the sexual assault survivor should include safety, timeliness, privacy, sensitivity, and competence.
- Sexual assault survivors may expect to receive comprehensive care of physical and emotional needs.
- Sexual assault survivors may expect to receive care from health care practitioners who are prepared by education and temperament to provide competent examination and treatment in the emergency department.
- Sexual assault survivors may expect to receive appropriate documentation, collection and preservation of evidence, and submission to policing agencies in accordance with current standards of forensic care.
- Emergency health care providers should receive preparation to equip them to provide appropriate care, forensic services, and referral services to adult and pediatric survivors of sexual violence and their families.
- Sexual assault survivors should not be denied the support of a person of trust or a representative of advocacy services, if desired.
- It is highly desirable that emergency departments employ SANE to provide comprehensive care to sexual assault survivors.
- Emergency registered nurses should collaborate to promote community awareness of sexual assault and should support community sexual assault prevention initiatives.

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Calling all instructors

If your students have put the work into a presentation, a case study, a disease process, research, etc., encourage them to write it up into a brief article to be published in **Outlook**. Our section editors will work closely with them to help in the process, and they can see their hard work in print, help to educate emergency nurses across the country and add a publication to their resume—a win/win situation!

Articles can be submitted to the Communication Officer, Stephanie Carlson, Box 31E, R.R. 1, Station Main, Regina, SK S4P 2Z1, ***communicationofficer@nena.ca***

SANE adventures

By Stephanie Carlson

As part of my being proactive in obtaining all the extra knowledge I can get for Sexual Assault Nurse Examiner (SANE) work, I arranged to spend time at the STD clinic downtown. Yesterday was the second of two afternoons and I found each one helpful. The nurses went beyond my expectations in explaining how their clinic works, how they follow up with patients, and in permitting me (with client permission) to observe a couple of exams. Time well spent! Yesterday, I watched one exam, observed a couple of client interviews, and followed the nurses with their preparation of slides and specimens for the lab.

After their last client had left and I asked my final few questions of staff, slipped my coat on over my khakis and polo shirt "uniform", tucked my lanyard and name tag into my coat, left the nurse area and went out into the reception area.

I looked at the bulletin board one last time to see if there was anything of value for emergency when a basket with a sign and the word "free" caught my eye. Anything free is automatically worth exploring, right? Realizing what the brightly coloured wrappers contained, I briefly considered picking up a few. I hate to pass up any freebies because no matter how unlikely it may seem at the time, the opportunity may come up to use them one day.

The more I thought about grabbing a handful on the way out, the less valuable they seemed. Given my age (not telling) and marital status (41st anniversary last winter) it seemed highly unlikely that I would have a personal use for them. Is this something we could pass out to company in our home? Um... no, I don't think so. Any aesthetic value for home or office? No, not really. As for using them at work... well, it would be insensitive to give out condoms to victims of sexual assault.

I left the clinic through their very well-marked door (this is important to the story) and pulled the door behind me. I looked up and found myself facing the husband of an old friend, who eyed me and then the door, me and the door again.

We had socialized with the couple a while ago but haven't seen either of them since my stay-at-home/Birkenstock-wearing/grind-your-own-wheat and make-your-own-bread/home schooling days when our kids were young (maybe 15 or 20 years ago). He wouldn't have known that I am working as a nurse again, if he even knew that I was ever a nurse. So here I am, exiting the STD clinic through their clearly marked door, wearing street clothes, trying to look inconspicuous.

It's amazing the thoughts that can run through your head in a brief moment. Will he recognize me after all this time? Did he see the sign on the door? Does he know what STD means? Should I say anything or just hold my head up high and act like a social visit to the STD clinic is something that women of my age routinely enjoy in our leisure? Should I say something about the tragic risk of picking up disease from public toilets? Should I fabricate a warning about an unpublicized epidemic of airborne syphilis?

He smiles broadly and greets me. Rats! He knows me. He probably knows what STDs are and has already formulated a plan for telling our entire shared network of old friends and no telling who else, that I was there. Is it significant that he doesn't extend his arm to shake hands?

In an instant I forgot to play it cool and act casual, forgot about public toilets and airborne syphilis (would that be sniffle-ous?), forgot that he might not know what an STD is. I lamely mumbled that I was there for work, which couldn't have appeared more improbable, especially since I stammered a bit and probably blushed. He was emerging from the travel clinic after getting his shots for a missionary trip to India. Swell.

Possibly my declaration that I was there for work is more believable than the other potential conclusion. When you see a grey-haired, middle-aged, matronly woman leaving an STD clinic, what are you supposed to think? Oh right! Don't tell me—I already know that HIV is running rampant in some seniors' complexes.

All I can say is this: I'm glad that I resisted the fleeting temptation to pick up a handful of give-away condoms. Bad enough to be seen departing from the clinic, without a handful of supplies in my hand! I learned a good lesson today. Sometimes passing up a bargain is a good thing. Condoms wouldn't have gone with our decor anyway, no matter how I might creatively have used them.

Stephanie Carlson, RN, SANE-A, is the SANE Coordinator of the Regina SANE program, which operates out of both Regina acute care hospitals.

From emergency nurse to legal nurse consultant and independent practitioner: Legal nurse consulting? What is that?

By Brenda Robson

I was watching television in the fall of 2007, one of those police investigative shows, and I found myself totally captivated by the testimony being provided by an intelligent, well-spoken, well-dressed witness under interrogation in a court room. It was one of those "aha!" moments for me, when the judge said, "Thank you nurse Smith, you can step down now." I sat up and said to myself, "That was a nurse, I can do that!" I immediately headed to my computer and researched "legal nurse" and over the next four hours I found a wealth of information... and a new career path!

I worked as an emergency nurse for 25 years, most of the time at the bedside. Experience in a few different roles had given me some insight, experience and the confidence to try something new. My roles as staff nurse, patient care coordinator, and clinical leader in emergency services for a health authority with 35 emergency departments provided a variety of opportunities, all of which included promotion of standards of care, risk management issues and policy/procedure development. I have always enjoyed the "sleuthing" that we do as emergency nurses and as nurse leaders or educators. When I read about legal nurse consulting I realized that this role is a perfect combination of utilizing clinical knowledge and expertise, research, analytical skills, report writing, communication, speaking to one's topic of expertise and promoting standards of care.

What is legal nurse consulting?

According to the American Association of Legal Nurse Consultants (www.aalnc.org), the primary role of a legal nurse consultant (LNC) is to evaluate, analyze, and render informed opinions on the delivery of health care and its outcomes. Legal nurse consultants have acted as collaborators, strategists, and educators by offering support in medically related litigation and other medical-legal matters in the following areas:

- personal injury
- product liability
- medical malpractice
- toxic torts
- workers' compensation
- risk management
- health care licensure investigation
- other applicable cases

The main role of a legal nurse consultant is to evaluate, analyze and provide informed opinions on the delivery of health care and its related outcomes. Legal nurse consultants practise in either the plaintiff or defence capacity for law firms, insurance companies, government agencies and risk management departments. There are many different areas in which LNCs can offer their support. In addition to medical malpractice cases, nurses work in personal injury claims, product liability, workers' compensation, toxic tort (personal injury caused by exposure to toxic chemicals from pharmaceuticals, consumer products or the environment), risk management, health care licensure, and other areas.

Much of our work involves being the educator: to the attorney, to the judge and members of the jury. We translate the medical jargon into everyday language. We explain different disease processes and conditions, tests, and lab values. We then explain why they were important to the case. In a medical malpractice case, the legal nurse consultant assists the attorney in reviewing the health record with a "triage" lens, helping to determine if the case has merit or not and identifying strengths and weaknesses of the case, as well as identifying important parties.

Once the attorney has decided that a case is going ahead and the services of the legal nurse are retained, the LNC utilizes his/her knowledge of the health care system and completes an in-depth, comprehensive case analysis. In this process, the nurse identifies if there are missing or altered medical records (who knows better than a nurse what is missing or not?), correlates all of the physician and nursing notes, lab reports, and procedures and provides a chronological timeline of every pertinent event. The LNC then researches the expected standard of care by looking at best practices, institutional policy/procedures, national specialty organization position statements and published standards of care.

A comparison between the care that was provided against the expected standard of care is completed. A written report is provided outlining the timeline of events and care that was provided, the standards of care and the nurse's opinion on whether the care provided met or fell below the minimum standard of care. The LNC may be required to defend the opinion in court. (www.aalnc.org)

In the course of their work, LNCs may engage in any of the following activities:

- organizing and analyzing medical records and related litigation materials
- preparing chronologies of health care events and comparing and correlating them to allegations
- conducting client interviews
- identifying standards of care, causation, and damage issues
- conducting literature research and summarizing medical literature
- helping to determine the merits or defensibility of a case
- providing education regarding health care facts and issues relevant to a case
- identifying and determining damages and related costs of services, including consulting with economists when preparing a cost analysis for damages
- assisting with depositions and trial, including developing and preparing exhibits
- assisting attorneys to develop case management and trial strategy
- locating and preparing demonstrative evidence
- collaborating with attorneys in preparing or analyzing complaints, answers, and motions for summary judgment; interrogatories, and deposition and trial outlines; witness lists and other pleadings; queries for direct and cross-examination; and document production request, trial briefs, demand letters, and status reports
- identifying, screening, retaining, and consulting with expert witnesses
- acting as a liaison among attorney, health care providers, clients, and experts
- attending independent medical examinations (IMEs).

Getting started!

The first thing I did was sign up for some education in legal nurse consulting. There are different educational opportunities available and a bit of on-line research will lead you to these opportunities.

After I completed the education, I experienced quite a learning curve over the following year. I had to learn about starting my own business and independent nursing practice. Once I had committed to this new career path it was easy to invest in myself. I took a course, attended conferences, purchased learning materials and, most importantly, sought out mentors in both the nursing and business worlds. I then pumped them for information. I decided to start my own business, I developed marketing material and began to market myself.

By the summer of 2008, I was ready and I accepted my first job, a medical malpractice case. My first case arrived in the mail. Wow! I was so excited to get started. I read through the entire package of documents to familiarize myself with the case and the issues, then sat down to do a chronology. I found myself documenting and making notes as I went through the case and soon realized that the learning curve is not around nursing. It is around how to market and run a business and develop good report-writing skills. The attorney is the expert on legal issues. The legal nurse consultant is the expert on nursing, the health care system and its inner workings. The importance of medical records with complete documentation was reinforced.

An example of one case involved a post-operative patient who had bled at home and came to the emergency department, a common scenario in an emergency department. The patient was admitted for observation overnight to monitor for ongoing bleeding. Once the medical record was reviewed and a chronology completed, it was evident that the patient's vital signs showed a tachycardia/hypotensive episode at the scene (home), normalization of vital signs and no further bleeding noted with the triage assessment and with the initial emergency physician and emergency nurse assessment (compensatory mechanisms for shock initiated). Documentation then noted an abnormal and continued steady rise in the heart rate throughout the four-hour emergency department stay and on the inpatient unit (signs of progressive shock). While the nursing documentation indicated abnormal signs and other signs of poor tissue perfusion along with evidence of possible continued bleeding, there was no evidence that any interventions were completed to address the assessment findings.

Nursing care is compared to the expected standard of care and the legal nurse consultant provides opinion on whether the nursing care met the expected standard of care or fell below it. In this case it would be expected that there would be a normalization of vital signs, as well as improvement in other indicators of early shock prior to a patient being sent from a critical care area to a general ward (fluid resuscitation). The admission orders were written within 10 minutes of the patient's arrival, with assignment to another physician as the most responsible physician. There was no evidence of notification of the most responsible physician of the sustained abnormal vital signs prior to the patient being sent to the general ward. As you can surmise, this patient went on to have a poor outcome, which is why the legal nurse consultant was involved in this case.

Since that time, I have worked in the area of medical malpractice and personal injury and have testified out of province as an "expert witness". I have also developed and delivered workshops for nurses on the topic of legalities of charting and documentation. I have provided presentations on this topic at our local hospital and at our provincial emergency nurse association education days. There are many aspects to legal nurse consulting and many different paths a legal nurse consultant can take. Legal nurse consulting is one aspect of a broader category of forensic nursing.

What is forensic nursing?

International Association of Forensic Nurses (www.iafn.com)

Forensic nursing is the application of nursing science to public or legal proceedings; the application of the forensic aspects of health care combined with the bio-psycho-social education of the registered nurse in the scientific investigation and treatment of trauma and/or death of victims and perpetrators of abuse, violence, criminal activity and traumatic accidents.

The forensic nurse provides direct services to individual clients, consultation services to nursing, medical and law-related agencies, and expert court testimony in areas dealing with trauma and/or questioned death investigative processes, adequacy of services delivery, and specialized diagnoses of specific conditions as related to nursing.

Forensic nursing involves the areas of interpersonal violence, forensic mental health, correctional nursing, legal nurse consulting, emergency/trauma services, patient care facility issues, public health and safety, and death investigations. The Forensic Nurses' Society of Canada (FNSC) is a uniquely Canadian organization for forensic nurses and was approved as an emerging special interest group of the Canadian Nurses Association in July 2007.

In the United States, there is an Association of Legal Nurse Consultants (AALNC) and a certification process. Legal nurse consulting is recognized as a nursing specialty. In Canada, legal nurse consulting is a growing field. There is the newly formed Legal Nurse Consulting Association of Canada (LNCAC). The first annual general meeting was held in May 2009. "The LNCAC was formed to provide support, resources, and a connection to all legal nurse consultants (LNCs) across Canada as we further develop this exciting profession across the country" (www.lncac.ca).

The shift to independent nursing practice has been very rewarding. The autonomy and use of acquired knowledge and expertise along with a flexible schedule is exactly what I was ready for. There is a network of mentors available and a growing field of expertise in forensic nursing including legal nurse consulting in Canada.

Resources

American Association of Legal Nurse consultants (AALN)
www.aalnc.com

Forensic Nurses Society of Canada (FNSC)
www.forensicnurse.ca

International Association of Forensic Nurses (IAFN)
www.iafn.com

Legal Nurse Consultants Association of Canada (LNCAC)
www.lncac.ca

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outlook
Kids' Play

Sucrose... Pediatric pain management

By Laura Ebenspanger, RN, BN

When children enter the emergency department, the likelihood of receiving invasive treatment such as a venipuncture or a heel lance is high. In order to assess, diagnose and treat the patient, certain procedures must be completed, many of which cause a painful stimuli for the child and the family. According to a research article conducted by Ali, Curtis, Jou, Klassen and Vandermeer (2007), steps can be taken to decrease the amount of pain to which many children are susceptible. The article "*A randomized controlled trial of sucrose and/or pacifier as analgesia for infants receiving venipuncture in a pediatric emergency department"* is a study conducted to test the effects of sucrose and the use of a pacifier as an analgesic.

An emergency department has a fast-paced environment, requiring quick and competent skills. "The ideal analgesic for procedural pain in the emergency department should have quick onset, be effective and have no side effects" (Curtis et al., 2007). Sucrose is thought to be a taste-induced analgesia lasting approximately five minutes (2007). The article delivers evidence to prove that sucrose is an effective form of pain management for infants under the age of three months, stating that crying time is reduced (2007). The effects of sucrose are then increased when used simultaneously with a pacifier (2007). Administering 2 ml of 44% sucrose two minutes prior to the procedure produced a therapeutic effect in the study. The study concludes that pacifiers and sucrose are inexpensive, easy to use, and have no serious side effects. Therefore, this form of analgesia should be used in a pediatric emergency setting.

If emergency departments can limit the amount of pain, it will decrease the stress on the patient, as well as the family. Applying the use of sucrose to children's emergency departments requires promotion and recognition of the effects of sucrose. This article brings to the attention that painful procedures are inevitable. However, if there is a way of minimizing the amount of pain, then why not do so? This form of analgesic may, in fact, improve the rates of venipuncture due to the decrease in crying time. It may also increase family comfort in being present in the room when procedures are performed. The protocol for administering sucrose came into effect during the past year at Children's Hospital in Winnipeg. With education and time, hopefully many nurses will recognize the positive effects of this form of analgesia, and using it will become second nature.

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outlook
Trauma Corner

Case study: The link between severe traumatic brain injury and coagulopathy

By Margaret M. Dymond, RN, BSN, ENC(C)

Severe traumatic brain injury (STBI) and the subsequent development of coagulopathy increase mortality in trauma patients (Stein, Dutton, Kramer, & Scalea, 2009; Talving et al., 2009). The following case study will highlight the link between STBI and the development of coagulopathy as a risk factor for poor patient outcomes.

Pre-hospital care

Emergency Medical Services (EMS) transported a 50-year-old male to the emergency department (ED). The patient was struck by a car while crossing the street, and found to be combative on the scene. Cervical spinal immobilization was initiated and the primary and secondary survey performed. The primary survey indicated an intact airway, decreased breath sounds bilaterally, weak radial pulses, and a Glasgow Coma Score (GCS) of 7. Secondary survey findings included head/facial/limb abrasions, abdomen soft, and stable pelvis. Initial pre-hospital interventions included advanced airway management and initiation of intravenous (IV) therapy. The patient was difficult to intubate with an endotracheal tube (ETT), therefore a Combitube® was inserted. During transport, the patient deteriorated and arrived to the ED in a cardiac arrest. Total pre-hospital to ED time was 35 minutes.

Table One. Initial lab results

Lab Results	Time: 0821	Time: 0854
HgB	131g/L	95g/L
PTT	66 sec	
PT-INR	1.5 sec	
PLT	104 10**9/L	
PH	<6.8	7.01
PO2	110 mmHg	66 mmHg
PCO2	>104 mmHg	88 mmHg
BE	-18 mmol/L	-13 mmol/L
Lactate	15 mmol/L	13.6 mmol/L

**arterial samples

Emergency department care

The patient arrived in the trauma room in full spinal protection, bagged with a Combitube®, CPR in progress and one peripheral IV catheter in situ. A primary survey was conducted by the trauma team leader (TTL). Blood was apparent in the oral cavity requiring suctioning. Breath sounds were difficult to assess. The Combitube® was removed and bag valve mask (BVM) ventilation was initiated. The patient was intubated successfully with an ETT using a glidescope. Breath sounds were noted bilaterally, but decreased. The surgery team was requested to insert bilateral chest tubes. Initial chest tube drainage was minimal. The patient was placed on a cardiac monitor showing bradycardia. No central pulse was palpated. Slow Pulseless Electrical Activity (PEA) cardiac arrest was present. The TTL ensured high-quality CPR was continued with the addition of appropriate interventions and medications including IV fluid boluses, Epinephrine, and Atropine. Supportive care included insertion of a gastric tube and a urethral catheter draining yellow urine.

Complicating the resuscitation attempt was an interstitial IV. Attempts to gain peripheral IV access were unsuccessful. The TTL requested a central venous access. The femoral artery was cannulated on the first attempt. Standard trauma laboratory tests were obtained. An arterial line system was set up and indicated systolic B/P of 90 with chest compressions. Central venous access was quickly achieved permitting infusion of IV fluids and medications.

During the initial resuscitation, the patient's pulse became palpable at intervals following administration of Epinephrine IV. The patient arrested twice more in the first 30 minutes of

care in ED and required CPR for short intervals. Further interventions included x-rays of the chest, cervical spine and pelvis. The radiographic abnormalities included rib and c-spine fractures.

Significant initial lab results (Table One) indicated a developing coaguloapthy, acidosis, and hemorrhage. The patient's hemodynamic status was optimized by the administration of two units of unmatched packed red blood cells.

Further diagnostic imaging was obtained including computer tomography (CT) exams of the head and neck. Results included a subarachnoid hemorrhage, massive cerebral edema, marked effacement of sulci, and atlanto-cervical dislocation. It was determined that these injuries were incompatible with life. No further CT imaging was ordered.

On return to ED from CT, the patient's vital signs were: B/P 90/70, HR 104. Head-to-toe exam findings were continuous bleeding from head and facial abrasions, a large amount of bloody drainage on the chest tube dressings, 400 mLs bloody drainage from the left chest tube, 100 mLs from the right chest tube, and frank hematuria.

Pathophysiology

The brain is rich in tissue thromboplastin. Once brain tissue is injured, thromboplastin is released and activates the clotting cascade. Damage to the cerebral vessels can activate platelets producing intravascular coagulation leading to consumption of platelets and other clotting factors. Plasmin is also activated, which will break down clots forming around sites of vessel injury causing fibrinolysis. These factors can lead to further hemorrhage at local sites of injury and systemically (Carrick, Tyroch, Youmens, & Handley, 2005; Cohen et al., 2007; Kushimoto, Yamamoto, Shibata, Sato, & Koido, 2001).

STBI results from the initial impact and injury, plus secondary factors post-insult (Carrick, Tyroch, Youmens, & Handley, 2005). Tissue hypoxia is a secondary factor that activates the inflammatory mediators and tissue thromboplastin in the brain. These factors cause further damage to cerebral tissues after initial impact. Inflammatory mediators further compromise brain tissue resulting in severe secondary injury to the brain (cerebral edema, ischemia, and infarction) (Miner, Kaufman, Graham, Haar, & Gildenberg, 1982). Hypoxia, hypotension, hypercarbia, and hyperglycemia were all present in this patient, which led to progressive damage to the cerebral structures. Patients who are acidotic are less able to clot due to inhibition of thrombin and platelet malfunction (Cohen et al., 2007; Martini, 2009). This can contribute to ongoing coagulopathy.

Discussion

The development of coagulopathy in STBI contributes to higher rates of mortality (Talving et al., 2009). The literature suggests that patients who have an STBI and coagulopathy have an increased risk of an adverse outcome and death. Talving et al. reported that patients with STBI who developed coagulopathy had a 50% mortality compared to 7% who had incurred an STBI with no coagulopathy. Miner et al. have reported the incidence of developing coagulopathy increases with the severity of the STBI in the range of 33% to 93%. Similar groups of studies have reported the incidence of coagulopathy after STBI between 15% and 100% (Cohen et al., 2007).

Some investigators have used GCS as a prognostic indicator: the lower the GCS, the greater the risk of coagulopathy with limited success. The assumptions were the lower the GCS, the greater the brain insult. Cohen et al. (2007) investigated the link between STBI with hypoperfusion and the development of early coagulopathy. They concluded that not all patients with STBI developed coagulopathy and that the onset of coagulopathy is closely associated with hypoperfusion in patients with base deficit >6. Patients with a low GCS and no hypoperfusion did not develop coagulopathy.

Several investigators have studied markers of coagulation and inflammation in patients with STBI and coagulopathy. Some research studies have concluded that markers of coagulation can be a prognostic indicator. Olson et al. (1989) reported that elevated PTT, and/or INR, and/or low platelet counts in patients with STBI was an indicator of increased mortality. Kushimoto et al. (2001) evaluated the components of the fibrinolytic system in patients with STBI and found that patients with coagulopathy had poorer outcomes.

A study by Talving et al. (2009) found independent risk factors in assessing outcomes in patients with STBI and coagulopathy. They include GCS<8, Injury Severity Score (ISS) of >16, hypotension upon admission, cerebral edema, subarachnoid hemorrhage, and midline shift. All of these factors were present in this case study.

Patients can become coagulopathic from multiple factors during resuscitation. Large volumes of crystalloid administration can lead to dilutional effects of clotting factors. Bleeding from other major injuries can lead to consumption of clotting factors (Stein, Dutton, Kramer, & Scalea, 2009). Hemorrhage from internal injuries could not be ruled out in this case, as a complete trauma diagnostic exam was not performed due to the severity of the head and neck injuries.

Treatment

Patients with STBI and coagulopathy are treated with replacing clotting factors and platelets to attempt to reverse bleeding. This is important to prevent ongoing hemorrhage in the brain and is required if surgical intervention is planned. Administration of fresh frozen plasma, cryoprecipitate, packed red blood cells, and vitamin K may be required (Carrick, Tyroch, Youmens, & Handley, 2005). A novel intervention currently being debated and studied is administration of recombinant Factor V11a as an option in some patients. Stein et al. (2009) have reported that administration of Factor V11a in patients with STBI and coagulopathy has not been proven to show a mortality benefit, but the investigators report a decrease in length of stay in ICU and decreased use of blood products in this population of patients.

Outcomes of case study patient

Due to the severity of the brain injury, the trauma team discussed the prognosis with the family. Care was withdrawn. The patient died several minutes later.

Summary

Patients with STBI who develop coagulopathy have an increased risk of morbidity and mortality. Not all patients with STBI develop coagulopathy, but patients with hypotension and hypoperfusion on admission to ED are at increased risk (Cohen et al., 2007). Trauma nurses should be monitoring standard coagulation profiles on their patients and must be prepared to intervene early to minimize complications and optimize outcomes (Carrick, Tyroch, Youmens, & Handley, 2009).

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Case study: Exercise-induced rhabdomyolysis

By Cathie Miller

A healthy 28-year-old firefighter presented to the emergency department with complaints of abdominal muscle pain after an intense cross-training workout. He usually worked out three to five times a week and had an intense workout wherein he did 150 repetitions on a sit-up machine. Twenty-four hours later he could not stand upright and complained of discoloured urine. A dip of his urine indicated large blood and trace of protein. He did not sustain a kidney contusion and did not have CVA tenderness on examination. His physical exam elicited significant abdominal muscle tenderness. Urine was sent for a myoglobin, which returned positive and blood was drawn, which indicated a serum creatine kinase (CK) of 69,400U/L (reference 38-174U/L).

Rhabdomyolysis is the destruction of muscle resulting in leakage of the muscle protein myoglobin into the urine. Myoglobin, a heme-containing protein component of the muscle cells, is excreted into the urine when muscle is broken down. It results in the production of red to brown urine. Because of rapid excretion, myoglobin does not produce a change in plasma colour unless renal failure limits myoglobin excretion. CK is an enzyme that is in the muscle cells and elevation in this serum level is a hallmark of rhabdomyolysis. CK is a protein that facilitates chemical reactions in the body. It is also present in cardiac muscle and brain. The levels of both of these proteins can be measured in the blood to monitor the degree of muscle injury from rhabdomyolysis. Myoglobin is cleared more rapidly from the plasma than CK and the CK levels can remain elevated in the absence of myoglobinuria.

Rhabdomyolysis can be caused by muscle trauma, crush injury, severe burns, physical torture, child abuse, prolonged lying on the ground, i.e., in people who fall or are unconscious and unable to get up for prolonged periods, prolonged coma, severe muscle contractions from prolonged seizures, cocaine use with related hyperthermia related to increased body temperatures, extreme physical activity such as running a marathon, drug or alcohol intoxication, low circulating serum phosphate, potassium, or magnesium levels, genetic muscle diseases, prolonged drowning or hypothermia, medications such as statins used to treat high cholesterol, viruses and some bacterial infections, severe hypothyroidism, lack of blood perfusion to a limb, inflammatory disorders of the muscle such as myopathies, myositis, dermatiomyositis, polmyositis and venom from snake bites in Africa, Asia and South America.

Rhabdomyolysis is not normally associated with exercise. It can be brought on by severe exertion such as marathon running or an unusual amount of high-impact callisthenics. When exercise continues long enough for the body to become depleted of oxygen and fat that are needed to continue producing energy, the body may begin to break down muscle fibres. It uses this in place of fat. This causes the release of myoglobin protein, which further breaks down to compounds that can harm the body. Early symptoms from exercise-induced rhabdomyolysis include red or brown urine, weakness and extreme muscle aches and tenderness. Exercise-induced rhabdomyolysis generally occurs in poorly conditioned individuals, but can also develop in fit people. Factors such as poor hydration, humid conditions, high outdoor temperatures and a genetic predisposition are risk factors. The incidence of exercise-induced rhabdomyolysis is not really known. One study tested 337 military recruits during their first six days of conditioning and found 40% of the recruits to have some degree of rhabdomyolysis. The syndrome has also been commonly reported in professional athletes during marathon races and ice-skating competitions.

Some of the complications of rhabdomyolysis are kidney failure that occurs due to the direct injury to the kidney and plugging of the filtering tubes by the muscle proteins impairing the kidney function. Compartment syndrome from the swelling and increased pressure in a confined area of the muscle injury can compromise circulation and endanger the affected tissue. This is most common in lower leg or abdominal wall injuries. As well, serum electrolyte abnormalities can be present causing hyperkalemia and hyperphosphatemia.

This 28 year-old-male was admitted to hospital for treatment of exercise-induced rhabdomyolysis with IV rehydration of normal saline and monitoring of his renal functions, electrolytes and muscle enzyme levels. Management includes plasma volume expansion with IV isotonic saline as soon as possible, monitoring the serum potassium, calcium, phosphate and CK levels and treatment of the underlying causes of rhabdomyolysis. He also received a sodium bicarbonate to alkalinize his urine. Twelve hours after initiating IV rehydration his CK was 56,380U/L. His CK continued to fall and 24 hours post-admission the level was 50,720U/L and 48-hour level was 37,120U/L prior to his discharge from hospital.

As this case illustrates, exercise-induced rhabdomyolysis may be associated with forms of excessive physical exertion, as well as cross training and weightlifting. The increased prevalence of such "extreme" training regimens requires an awareness of this syndrome, as proper treatment is mandatory in order to prevent several serious complications, in particular, the development of acute renal failure.

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About the author

Cathie Miller, RN(EC), ENC(C), has been an emergency room nurse for the last 20 years and a sexual assault nurse examiner for 10 years. For the last one-and-a-half years, she has been working as a nurse practitioner at Guelph General Hospital in the ER.

A CPR success story

By Brent Hobbs, RN, BSN, CNCC(C)

September 23, 2009

I have performed cardiopulmonary resuscitation (CPR) countless times during my career as a registered nurse and paramedic. Rarely have I witnessed a positive outcome from CPR efforts. That changed on April 19, 2009. On that day, I was competing in a masters swim meet. In the heat before my race, a 69-year-old male was competing in the 200-metre freestyle. At the 125-metre mark, he stopped swimming. He appeared to be relaxing on his back, face up. Everyone who was watching realized this was no rest break! Luckily, there was a swim official in close proximity who immediately recognized the seriousness of the situation and jumped into the pool to save the athlete. Fortunately, the patient was in the shallow end, so the official was able to extricate the swimmer face-up to prevent aspiration. I and a respiratory therapist (RT) responded a few seconds later. A quick breathing and pulse check revealed the patient was in cardiac arrest. Chest compressions were started immediately and my RT partner assessed the patency of the patient's airway soon after that. While performing the new CPR technique (American Heart Association, 2005), the lifeguards summoned an ambulance, hooked up portable oxygen to the pocket mask, and retrieved an Automatic External Defibrillator (AED). Within one minute of CPR we had an AED attached. Analysis revealed "no shock" advised. We carried on with compressions and ventilations at a ratio of 30:2 for another minute. A short while later, my RT colleague noted the patient was making "agonal" respirations, but we carried on with compressions without pausing for a pulse check. A minute later, we were about to re-analyze the patient's cardiac rhythm with the AED when he started coughing. At that point, a pulse check confirmed the return of spontaneous circulation. Soon thereafter, the patient's colour "pinked" up, his radial pulse was 110 and regular and his respirations were 28 and effective. A minute later, our swimmer woke up and motioned that he wanted to get back into the pool to finish his race! We didn't let him. By that time, the ambulance service was in attendance (within five minutes of the call). Our patient was transferred to the local coronary care unit where tests confirmed no damage to his myocardium, nor did he experience neurological sequelae. This positive outcome was a direct result of performing effective CPR.

The new CPR technique recommended by the American Heart Association (2005) emphasizes that CPR performed immediately after collapse can double or triple the victim's chance of survival. To be effective, CPR must restore adequate coronary and cerebral blood flow. Interruptions in chest compressions lower coronary perfusion pressure and decrease rates of survival from cardiac arrest (Kern, 2002). In the scenario described above, my RT colleague and I placed emphasis on compressions over ventilations. For example, we started compressions **before** ventilations. We also did not stop compressions while AED pads were being applied, nor did we stop compressions when the patient exhibited "agonal" respirations.

We attribute our patient's survival from cardiac arrest to several factors: a) quick recognition of an emergency; b) extrication from the water without risk of aspiration; and c) timely commencement of CPR (within 15 seconds of the event); and emphasis on effective chest compressions [depth of one-third to one-half the depth of the chest and a rate of 100 compressions/minute (American Heart Association, 2005)]. As a result of our efforts, we look forward to swimming with our patient in the near future.

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The NENA Bursary

NENA recognizes the need to promote excellence in emergency care and, to this end, to provide financial aid to its members. NENA will set aside a predetermined amount of monies annually with the mandate of providing a high standard of emergency care throughout Canada. All sections of the emergency nursing team are eligible for consideration including staff nurses, managers and educators.

Applications must be submitted prior to the spring Board of Directors meeting of NENA for review by the standing committee for bursary disbursements. On April 1 of each year the number of bursaries awarded will be determined by the number of registered members per province for that NENA fiscal year i.e.:

1-99 members:	1 bursary
100-199 members:	2 bursaries
200-299 members:	3 bursaries
300-399 members:	4 bursaries
400-499 members:	5 bursaries
500-599 members:	6 bursaries
600 + members:	7 bursaries

One bursary is to be available to NENA Board of Directors members and one bursary per year will be available to an independent member.

Successful candidates can receive a bursary only once every three years.

NENA Bursary application process

Each candidate will be reviewed on an individual basis and awarded a number of points as set out below:

1. Number of years as a NENA member in good standing
- 2 years ..... 1 point
- 3–5 years ..... 2 points
- 6–9 years ..... 3 points
- 10 + years ..... 5 points

2. Involvement in emergency nursing associations/groups/committees:
- Provincial member ..... 1 point
- Provincial chairperson ..... 2 points
- Special projects/committee — provincial executive ..... 3 points
- National executive/ chairperson ..... 5 points

3. Candidates with certification in emergency nursing and/or involved in nursing research will receive an additional five points.

If two candidates receive an equal number of points, the committee will choose the successful candidate. All decisions of the bursary committee are final.

Each application will be reviewed once per spring board meeting.

Preference will be given to actively involved members of NENA and those actively pursuing a career in emergency nursing. Those members requesting assistance for emergency nursing certification, TNCC, ENPC, CATN, as well as undergraduate or post-graduate studies that would enhance emergency care will also receive preference.

Candidates must have completed Forms A, B and C (included with this issue of **Outlook**). The provincial director may forward applications at the spring board meetings.

Any incomplete forms will be returned to the provincial director for correction if possible.

Eligibility
- Current RN status in respective province or territory. (Proof of registration required.)
- Active member in NENA Inc. for at least **two** consecutive years. (Proof of membership required.)
- Working at present in an emergency setting which may include:
  - Emergency department
  - Nursing station
  - Pre-hospital
  - Outpost nursing
  - Flight nursing

Application process

Candidates must complete and submit the following:

a. NENA Bursary application form "A"
b. Bursary reference form "B"
c. 200-word essay
d. Photocopies of provincial registered nurse status and NENA registration

Provincial representative responsibilities:

a. Completes bursary candidate's recommendation form "C"
b. Ensures application forms are complete before submission
c. Brings to Board of Directors meeting all completed applications

Selection process

The standing committee for bursary disbursements will:

1. Review all applications submitted by provincial representatives and award bursaries based on selection criteria.
2. Forward names of successful candidates to the Board of Directors for presentation.

outlook
The NENA Bursary

NENA Bursary application form "A"

Name: _____ Date of Application: _____

Address: _____

Phone numbers: work (_____) _____ - _____; home (_____) _____ - _____; fax (_____) _____ - _____

E-mail: _____

Place of employment: _____

Name of course/workshop: _____

Date: _____ Time:_____ Length of course: _____

Course sponsor: _____Cost of course: _____

Purpose of course: _____

Credits/CEUs: _____ ENC(C) Certified: ❑ Yes ❑ No

Previous NENA Bursary: ❑ Yes ❑ No Date: _____

Please submit a proposal of approximately 200 words stating how this educational session will assist you and your colleagues to provide an improved outcome for the emergency care user: Attached?: ❑ Yes ❑ No

Ensure photocopies of provincial RN registration and provincial emergency nurses association membership are included with your application: Attached?: ❑ Yes ❑ No

NENA Bursary application form "B"

I acknowledge that _____ (name of applicant) is currently employed in an emergency care setting. This applicant should receive monies for _____ (name of course).

Reason: _____

Other comments: _____

_____

Signed: _____ Position:_____

Address: _____

NENA Bursary application provincial director's recommendation form "C"

Name of bursary applicant: _____ Province: _____

Length of membership with provincial emergency nurses group: _____

Association activities: _____

_____

Do you recommend that this applicant receive a bursary? ❑ Yes ❑ No

Reason: _____

Provincial director signature: _____ Date: _____

NENA Award of Excellence application form

Forward all submissions to the provincial representatives by January 31 of each year. Incomplete or late applications will not be eligible for consideration. Successful candidates will be presented with awards at the annual general meeting. In order to facilitate the process of the applications, the nominator will involve the nominee in the submission and verification of information.

Award of Excellence in: _____

Nominee: _____ Address: _____

_____ Postal Code: _____

Phone: work (_____) _____ - _____; home (_____) _____ - _____; fax (_____) _____ - _____

E-mail: _____

Employer: _____ Current position: _____

Nominator: _____ Address: _____

_____ Postal code: _____

Phone: work (_____) _____ - _____; home (_____) _____ - _____; fax (_____) _____ - _____

Letter of support (1) from: _____

Letter of support (2) from: _____

Signature of nominee: _____

Signature of nominator: _____ Date: _____

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